

Families and Friends for Drug Law Reform (ACT) Inc.

committed to preventing tragedy that arises from illicit drug use

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NEWSLETTER

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Next Meeting

Thursday, 27 May

Meeting 7:30pm

at St Ninians Uniting Church,
Cnr Brigalow and Mouat Streets,
Lyneham

Members are encouraged to attend

Refreshments will follow

Meeting dates:

Families and Friends for Drug Law Reform meet on the **fourth Thursday** of each month except December and January. Unless otherwise advised the venue is St Ninian's Uniting Church, Cnr Mouat and Brigalow Sts, Lyneham. Meetings commence at 7.30pm and usually finish around 9pm with refreshments.

Expected dates for meetings for 2004 are:

24th June, 22nd July, 26th August, 23rd September, 28th October, 25th November.

Any enquiries please phone 6254 2961.

Drug Action Week

FFDLR is planning a forum to be held during Drug Action Week, 21 – 26 June 2004. The forum will aim to bring together a discussion on the relationship between drugs and the ACT's Social Plan.

We also plan to have a stall in Garema place on Saturday 26 June and are looking for volunteers to assist in manning that stall.

Editorial

Cannabis usage has been a niggling problem for governments for many years. There have been contradictory health claims about it. Because it is illegal negative stories about it are exaggerated and because it is illegal it pushes the panic button of parents.

This is not to say that it is without problems – all drugs have side effects – but prohibiting a drug makes the situation worse.

Cannabis harms, if ranked with other drugs, probably rank below tobacco and below alcohol. And certainly our piecemeal attempts to control it have been less than successful.

Recognising the costs for police resources and the effect on the life chances of a person prosecuted in a

criminal court for simple cannabis use, South Australia introduced, in 1987 an expiation notice system whereby a person could cultivate up to 10 plants and possess a small quantity for personal use without criminal penalty, but instead be fined.

This situation prevailed from 1987 to 1999 and seemed to work well. Police workload was reduced, users did not attract a criminal record, and surprisingly for opponents of the scheme, usage of cannabis in that state was not significantly different to that of other states.

However there was an outcry from NSW police who complained that the cannabis expiation notice system in South Australia was the cause of the importation of SA cannabis into NSW. People, they argued, clubbed together to produce large quantities of cannabis to sell over the border into NSW. Many had established indoor hydroponic growing facilities, which the police found more difficult to detect.

The SA government responded by changing the legislation, reducing the number of plants that could be grown down to one. It is currently considering introduction of legislation to ban indoor hydroponic growing.

Here in the ACT where we also have a similar scheme, the police have made a number of successful raids on houses where cannabis had been grown hydroponically. No doubt more remain undetected.

Generally the more populous states, NSW, VIC and QLD, adhere to the criminal penalty model (with variations). A model which deters neither user nor producer/dealer and is resource costly for police.

The demand for cannabis appears to be constant, guaranteeing a steady market for the drug. But the stronger laws prohibit (a legal) supply and thus force the drug onto the blackmarket. Because it is sold through the blackmarket the price will be higher than it would be through legal markets. Assuming production costs are similar, compare the \$7 price of 20 cigarettes (30c each), arguably more dangerous but legal and taxed, to that of \$25 for one gram (or 3 joints @ \$8.30 each) of illegal and untaxed cannabis and one gets some idea of the profit available.

Given that the type of law makes no difference to usage, but does raise costs for police and both monetary and social costs for users, is there a more effective and less costly way?

A uniform expiation notice system throughout Australia would be one option. It would reduce the cross border trading and reduce some of the friction between states. It would reduce the impact on individuals and the effects on their future life chances (*see also Dept of*

Health Monograph #43 by Simon Lenton). And it would reduce the police workload significantly because issuing and processing an expiation notice requires less time. If the statistics remain true to form there would be no greater use and no greater health impact than there is now and users would be more likely to seek treatment. Note that in a later article that even Russia has followed this line.

Another option would be to bring the whole business out of the dark shady corners into the light and with rigorous controls (such as no advertising, warning labels and quality and strength controls) allow cannabis to be sold through a legal market. It would have the benefits identified above. In addition it would significantly reduce the black market and it would enable better monitoring and regulation, where none currently exists, by a democratically elected government. And that government would garner a tax revenue that could help the seriously under resourced drug and alcohol sector.

No More Children

ABC's Life Matters ran an issue about removing children from drug addicted parents. In response to an invitation to make comment Bill Bush wrote this letter.

Tue, 11 May 2004

To: Lifematters

I was torn between weeping and howling with rage at your "No more children" report on Tuesday.

It was the excellence of your coverage, not any defects that caused the pain - the suffering of children of drug affected parents and of the parents themselves. It is familiar to those of us associated with groups such as Families and Friends for Drug Law Reform or who are on telephone support lines.

Yes, yes the interests of children must be paramount but Diana Lieberman, Executive Director of the New York Civil Liberties Union,ss is right. Prohibiting drug addicted parents from having children will at best be ineffective. Most likely it will compound the suffering of both parents and children. Much the same could be said of the standard removal of babies from such parents that Gillian Calvert, the NSW Commissioner for Children and Young People, seemed to be saying NSW now appears to permit.

A mother who fears that her child will be taken from her because of her drug use or that she will be otherwise punished will not seek help essential for her child. For every child "rescued" from such a parent the life chances of an unknown number will be diminished.

Both your commentators saw "treatment" for the parents as the best way out but what is this saying?

All too often in our experience it amounts to an insistence that drug users should overcome their addiction before anything else.

Here the call for treatment is driven by a stern moral position that there is nothing worse than that condition: that someone addicted to an illicit drug like heroin, if not a legal one like alcohol, has become less than human.

They are meant to put the rest of their life on hold while they grapple with a chronic relapsing condition that an addiction - any addiction - is.

So yes, pregnancy will be an incentive for a woman to kick her habit but pregnancy is hardly a stress free time. What about the other stresses in her life: those that may have led her to take up drugs in the first place; problems with the criminal law because of her stealing, dealing or prostitution to support her habit; relationship problems with her partner or family; the prospect of bringing up the child?

I have heard of few drug dependent parents who do not love their child or who want anything but the best for it. I also know of drug dependent parents who are good examples for any of us. There are others who, though they love their children, are not good parents. In spite of their best intentions, keeping "clean", caring for a child and managing other cares of life are all just too much.

A paralysing fog of shame envelops insistent drug dependence. It thickens at every one of the expected relapses.

What makes many of us so angry is that it need not be like this. Depending on the type of drug, people can live stabilised, responsible lives while still dependent. In the case of heroin this is proven beyond reasonable doubt by a century of clinical experience in the United Kingdom and trials in Switzerland and The Netherlands among a population of the most severely dependent and dysfunctional drug users who had "failed" all other available treatments. There is a stubborn denial of this fact.

To say that use of a drug is wrong and should be discouraged because it can be addictive is fine. To pursue a drug free objective without regard to the life of the addicted user or the wellbeing of the user's family is to base our health and social policy on an obsession.

We know that drug dependency is associated with many of the most potent risk factors for school drop out, mental illness, crime, suicide and much more. The answer is not necessarily to overcome addiction but to manage it. A parent on an adequate maintenance dose of, say, an opiate will no longer neglect his or her child while hanging out for the next hit. The grim logic of carrying on as we are now will move us from court orders against drug dependent people having children to forced sterilisation. We treat addicted drug users as lepers used to be. We are pushing them and those associated with them to the margins of society: to prisons, mental institutions and the streets.

Without a change of mindset about addiction the crisis in child protection evident in nearly every jurisdiction throughout Australia will intensify. Addiction to illicit drugs is not the only factor that puts children at risk but it is implicated in the majority of the most intractable cases. The same can be said for nearly all the other most serious social problems in this country. The economic costs alone are becoming insupportable. While the key elements of drug policy are determined by the Federal Government, the lion's share of budgetary costs

falls on the States and local governments who cannot meet them.

There is much talk of social capital. We in Families and Friends for Drug Law Reform witness it winding down. It is known that a high percentage of children without any particular risk factor in their background will try an illicit drug. Risk taking is a recognised facet of adolescent behaviour. A small percentage of these will become addicted. This can place an enormous strain on the family but there are reasonable prospects if the family keeps lines of communications open. Should the drug using member have a child herself there are, at least, grandparents who can support it. Grandparents can lessen the higher risk of their grandchild also moving onto drugs or into other trouble. In the next generation that support will no longer be there.

Families and Friends for Drug Law Reform sponsored a forum on the impact of drugs on agencies that do not have drugs as their focus. The director of an A.C.T child support service, Marymead, spoke about what so often happens to the third and subsequent generations:

"We see toddlers who are often looking after themselves for significant periods of time when their parents are either physically or mentally unavailable to them. They have inadequate food and sleep. Terrible accidents sometimes happen to them. They suffer burns, have falls from quite high places. And the chaos of the household often means that health needs are not met" (transcript at " Drugs affect all sectors of our community ").

It takes several generations to reach this point. The damage, though, is not inevitable. On the basis of overseas evidence most of the damage is avoidable if we stop insisting that addicted parents first overcome their addiction. Only when we think in terms of managing addiction as just one element in the life of troubled human beings will we be able to repair the damage magnified through generations.

Bill Bush

Progress Report on The Opiate Program (Top)

What has the TOP service been doing recently?

The service, begun in April 2002 in the ACT, was intended to help GPs and opiate dependant patients in the effective management of the treatment of these patients. TOP has improved access to treatment for a significant number of opiate dependant people in the community and helped participating GPs to manage those they have been treating. The service is available to both non-indigenous and indigenous people. Statistics are not available as to the precise number of people with an opiate addiction or dependance on other substances to which the service now potentially extends. However, it is clear that the service has been used by only a relatively small proportion of the people in the general community with an addiction to opiates. Probably a higher proportion of eligible indigenous patients have availed themselves of it.

Because of staff resource limitations, at present the TOP team cannot responsibly take more pro-active measures to bring to the attention of potential patients the availability of the service - additional patients' needs could not be met.

A very positive development is that five of the six recommendations made in a TOP Evaluation report in 2003 have been implemented. These actions are:

1. The TOP service has been extended to cover the management of patients with amphetamine and benzodiazapine dependancy and the TOP inclusion criteria have been altered accordingly.
2. A Mental Health nurse began working with the the TOP program in November 2003 to assist GPs in managing patients with co-morbidity (a drug addiction and a mental health condition).
3. Since November 2003 the TOP team has been based at the Tuggeranong Medical Practice.
4. In November 2003 the TOP funded nurse position at Winnunga (Aboriginal medical service in Ainslie) was increased from part-time to full-time.
5. The TOP nurses have been reclassified to Level 3, Clinical Nurse Consultant positions.

The TOP team and the Advisory Committee produced a draft policy to embrace the new TOP mental health capacity. Aspects of the policy include a clear definition of TOP patients who have a mental health issue; a process which includes screening for comorbidity at every initial visit with TOP; referral to and collaboration with existing mental health services; access for carers of TOP patients to a brief intervention to enable them to access existing support services - in conjunction with the carer's GP.

At present TOP engages with 28 GPs (these include 16 methadone prescribers). Of those GPs, 55% are female.

Since inception the TOP mainstream program has engaged with 57 patients and the Winnunga Aboriginal medical program with 50 patients. The staff capacity for each program is currently almost fully extended. Yet there could be a significant number of additional TOP patients as, in November 2003, the ACT Government provided funding for an additional 100 methadone treatment places in the community (ie places, at community pharmacies, for dosing) and a significant number of these has not yet been taken up.

Financial position:

There has been no new funding made available to TOP for the next financial year. (The provision of funds for the 3.1 FTE has been maintained). Thus the TOP program will be unable to accommodate a significant number of additional new potential patients and the TOP team will therefore be constrained in seeking to encourage a greater percentage of its potential clientele to benefit from access to the program.

Who are the TOP patients and what are the main treatment measures?

Of the mainstream TOP patients 21% were current patients, at 31 December 2003. Of the Winnunga pa-

tients 80% were then current. The mainstream clientele are predominantly female - unlike the position in other alcohol and drug programs. The average age of TOP mainstream patients is 32.7 years, whilst in the Winunga based program the average patient age is much lower - 24.2 years.

Fifty two percent of mainstream TOP are injecting drug users (IDUs) all of whom appear to be using risky injecting behaviours. In their management of patients TOP nurses advise on avoiding this risk-taking .

Forty four percent of TOP patients who were IDUs reported having injecting problems in the past month and 20% had overdosed in that period. By providing needle exchanges the TOP nurses are contributing to a potential reduction in risky injecting behaviour by TOP patients.

As to the incidence of Hepatitis C, of the 54% of TOP patients who provided data, 32% were Hepatitis C positive, 35% were negative and 32% did not know their status.

TOP is therefore in a position to assist with the prescribing of S100 medications and the active management of TOP Hep C patients.

The most common TOP treatment interventions in the six months to 31 December 2003 were: brief intervention (30%); methadone maintenance treatment (19%); and community opiate withdrawal (19%).

Of mainstream TOP patients, 60% completed their treatment intervention while 35% remained in the program for one month and 15% for 6 months or more.

As to their mental health, 52% of mainstream TOP patients had a mental health problem (determined according to criteria in TOP's draft mental health policy).

In the 30 day period before survey, the drugs used by mainstream TOP patients included tranquilisers with heroin (76%) and a much lower figure of 13% for amphetamines with heroin.

The ACT Division of General Practice is reporting to ACT Community Health that its service is 'uniquely placed to form long term relationships with patients in general practice that have dependency problems with prescribed opiates other than methadone. TOP has demonstrated a good success rate in assisting GPs to stabilise these patients and reduce their prescribed opiate intake'.

Contacts with the Pharmacy Guild and CAHMA

The TOP team recently sent an article to the Pharmacy Guild and made a presentation to a well-attended Guild meeting in March 2004. TOP team members went to each dosing pharmacy and spoke with the pharmacist. They left TOP brochures for customers.

The team is seeking to work with GPs to support the primary health care needs of CAHMA members who may be finding barriers to obtaining primary care. Discussions with CAHMA are taking place to achieve this objective.

Transfer of patients from the Alcohol and Drug Program (ADP) Clinic to Private Prescriber

There have been discussions by TOP Committee and Team members with senior Alcohol and Drug Program personnel about improving the provision of information about each patient transferring from the Woden ADP Clinic to a prescribing GP who is receiving a Clinic patient. Concern was also expressed during those discussions about the need for these patients to be given more information about TOP services.

Conclusion

The TOP program has become well established during the 2 years of its existence. The TOP team is providing a valuable service to those who have an addiction to an opiate or an amphetamine or benzodiazepine. Originally it was authorised to deal only with those with an opiate addiction but it can now cover those with dependence on the latter two groups of substances.

The TOP service has been valuable to the indigenous community - hard hit by drug dependency - as well as the mainstream community. The TOP team has recently been augmented by the appointment of a nurse qualified to treat patients with co-morbidity - a very important expansion of the nursing expertise of the team, particularly as half of the TOP patients have a mental health problem.

Valuable relationships have been established with the other stakeholders in the alcohol, drug and mental health fields, both public and private, so that potential and actual TOP patients benefit. However, much still needs to be done if these relationships are to be as productive as possible.

Russia Enacts Sweeping Reforms in Drug Laws: No Jail for Possession

A news extract from the Drug Reform Coordination Network, www.drcnet.org. 5/14/04

DRCNet reported in March that Russia was on the verge of making dramatic reforms to its draconian drug laws after the Duma passed legislation that would remove criminal penalties and the possibility of jail time for simple drug possession. But then the wheels flew off the whole process as drug warriors within the Russian government attempted to turn the reform on its head by defining the quantities of each drug that would constitute possession for personal use at levels so low as to render the reforms meaningless, or worse.

Now the drug warriors have been fought off, and reformers have managed to get quantities set at levels that will keep hundreds of thousands of Russian drug users out of prison. Under the old law, possession of even a single marijuana cigarette could garner a three-year prison sentence. According to Russian authorities, somewhere between 200,000 and 300,000 people are currently serving time for drug offenses.

Read the full story at:

<http://stopthedrugwar.org/chronicle/337/russia.shtml>